Medical Health **DOB: _____**

What would you consider your general health to be? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Primary Care Physician Name: _____ Physician Phone #: _____

Are you taking any medication? Yes ☐ No ☐ If Yes, Please List Below:

Medication: _____ For what purpose? _____

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Do you have OR have you ever had the following medical conditions:

Abnormal Blood Pressure: High/Low	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐
Abnormal Bleeding	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐
AFib	Yes ☐ No ☐	Heart Surgery	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Hepatitis Type_____	Yes ☐ No ☐
Angina (Chest Pain)	Yes ☐ No ☐	HIV+/AIDS	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Kidney Disease/Problems	Yes ☐ No ☐
Artificial Heart Valves	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Artificial Bones/Joints	Yes ☐ No ☐	Lung Disease/COPD	Yes ☐ No ☐
Asthma/Difficulty Breathing	Yes ☐ No ☐	Mental Disability	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Mental Illness	Yes ☐ No ☐
Cancer Type_____	Yes ☐ No ☐	Mitral Valve Prolapse	Yes ☐ No ☐
Chemotherapy or Radiation Treatment	Yes ☐ No ☐	Organ Transplant	Yes ☐ No ☐
Colitis/Ulcers	Yes ☐ No ☐	Osteoporosis	Yes ☐ No ☐
Congenital Heart Defect	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐
Dementia/Alzheimer's Disease	Yes ☐ No ☐	Rheumatic Fever/Scarlet Fever	Yes ☐ No ☐
Diabetes Type I or II	I ☐ II ☐ No ☐	Steroid Therapy	Yes ☐ No ☐
Epilepsy/Seizures	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Frequent/Severe Headaches	Yes ☐ No ☐	Substance Abuse Problems	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐	Thyroid Problems	Yes ☐ No ☐
Hay Fever/Sinus Trouble	Yes ☐ No ☐	Tuberculosis (TB)	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐	Tumors	Yes ☐ No ☐

Are you allergic to: Penicillin:☐ Codeine:☐ Sulfa Drugs:☐ Erythromycin:☐ Dental Anesthetics:☐ Iodine:☐ Metals/Nickel:☐
Aspirin:☐ Ibuprofen:☐ Latex/Plastics:☐ Barbiturates:☐ Any Other Medications/Materials? _____

Do you take antibiotics prior to dental treatment?	Yes ☐ No ☐	Are you taking any blood thinners?	Yes ☐ No ☐
Are you subject to prolonged bleeding?	Yes ☐ No ☐	Are you subject to fainting spells?	Yes ☐ No ☐
Do you have excessive urination and/or thirst?	Yes ☐ No ☐	Do you use tobacco products?	Yes ☐ No ☐

Have you ever had or are you currently getting IV Zoledronic Acid Treatments (such as Zometa or Reclast)? Yes ☐ No ☐

Please list any Major Surgeries: Year: _____ Type of Surgery: _____ Year: _____ Type of Surgery: _____

If you have any other medical problems not listed please explain: _____

Women: Are you or could you be pregnant? Yes ☐ No ☐ If yes, expected due date? _____ Are you nursing? Yes ☐ No ☐

Dental Health: Previous Dentist's Name _____ Previous Dentist's Phone #: _____

Reason for your visit today: _____ When was your last dental visit? _____

Have you ever experienced problems associated with previous dental treatment? Yes ☐ No ☐ Explain: _____

Are you experiencing any tooth or mouth pain? Yes ☐ No ☐ Explain: _____

Are your teeth sensitive to hot, cold, or anything else? Yes ☐ No ☐ Explain: _____

How often do you brush your teeth? _____ How often do you floss? _____

Type of bristles on your toothbrush? Soft ☐ Medium ☐ Hard ☐ Do you use an electric toothbrush and/or WaterPik? Yes ☐ No ☐

Do your gums bleed when brushing? Yes ☐ No ☐ Do your gums bleed when flossing? Yes ☐ No ☐

Do you use a Night Guard? Yes ☐ No ☐ Do you use a Sleep Apnea Device or Snore Guard? Yes ☐ No ☐

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐ If no, what would you change? _____

Would you like your teeth to be whiter? Yes ☐ No ☐

I affirm that the information I have provided on this form is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my status. I authorize the staff of Oak Hills Dentistry to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Name (Please Print)	Patient Signature	Today's Date

TMJ History & Questionnaire

Patient Name: _____

Have you ever been diagnosed with a problem involving either jaw joint?

☐ **No** ☐ **Yes** If yes, indicate location: ☐ **Right** ☐ **Left** ☐ **Both**

Do you notice clicking, popping, or grinding noises when opening or closing your mouth?

☐ **No** ☐ **Yes**

If yes: ☐ **Clicking** ☐ **Popping** ☐ **Grinding** **Which side?** ☐ **Right** ☐ **Left** ☐ **Both**

Does your jaw ever feel like it catches, locks, or gets stuck?

☐ **No** ☐ **Yes** If yes: ☐ **Open** ☐ **Closed** ☐ **Both**

Do you have frequent headaches?

☐ **No** ☐ **Yes** If yes, how often and when: _____

Do you clench or grind your teeth, or have you been told that you do?

☐ **No** ☐ **Yes**

Do you have a history of trauma to your chin or jaw?

☐ **No** ☐ **Yes**

Additional Comments:

_____

_____